MICHIGAN PHYSICAL THERAPY ASSOCIATION

1390 Eisenhower Place, Ann Arbor, Michigan 48108
Phone: (800) 242-8131 or (734) 929-6075 (Local) – Fax: (734) 677-2407 – mpta@mpta.com – www.mpta.com

DATE: Tuesday, May 20, 2014

TO: Michigan House Health Policy Committee

Representative Gail Haines, Chair
Representative Mike Callton, Majority Vice-Chair
Representative Hugh D. Crawford
Representative Bob Genetski
Representative Mike Shirkey
Representative Frank Foster
Representative Tom Hooker
Representative Ken Yonker
Representative Dale Zorn
Representative Joseph Graves
Representative Klint Kesto
Representative Martin Howrylak
Representative George Darany, Minority Vice-Chair
Representative David Knezek
Representative Kate Segal
Representative Thomas Stallworth
Representative Winnie Brinks
Representative Phil Cavanagh
Representative Phil Phelps

RE: Direct Consumer Access to Physical Therapy

Thank you Chairperson Haines, Vice-Chair Callton and members of the House Health Policy Committee for providing me this opportunity to speak about direct consumer access to physical therapy. Direct access is available to citizens in 48 states and the District of Columbia who no longer require a referral by a physician for physical therapy evaluation and treatment. The first states to legislate direct access occurred over 50 years ago – none have ever been rescinded. It is also noteworthy that the United States Military began permitting direct access to physical therapy in the late 1970s.

Only Michigan and Oklahoma still do not allow direct access to physical therapy treatment.

My name is Sue Talley. I am a physical therapist, have been a physical therapy faculty member at Wayne State University for over 30 years (including 10 years as Program Director) and I am currently the President of the Michigan Physical Therapy Association (MPTA). On behalf of the MPTA, I urge you to consider the benefits of direct consumer access to physical therapy. There is a package of Senate bills (SB 690 – 694) we believe are being voted on by the Senate as we speak that deals with direct consumer access. Because the bills are not properly before this committee we will not detail the responsible compromise that was forged between our association and physician groups, but we would like to thank the Michigan State Medical Society and the Michigan Orthopedic Society for their professionalism and engagement over the past 14 months of discussions surrounding this topic. We appreciate their transparency and respect for the negotiating process.

Direct consumer access to physical therapy allows individuals to seek the services of a physical therapist directly rather than first requiring a physician visit to obtain a prescription. Direct consumer access would allow individuals to select physical therapy as their entry point into the health care system. Michigan citizens and members of the physical therapy community have been advocating this increased choice for over 30 years. Direct Consumer Access to Physical Therapy services **does not change the physical therapy scope of practice**. Direct Consumer Access only removes a barrier and allows physical therapists to practice to the full capacity of their education and professional practice standards.

The evidence is clear. Direct consumer access has led to cost savings in other states – for both consumers as well as insurers - in an environment where health care costs are soaring. Fewer physical therapy visits are needed when consumers access physical therapy directly. A study conducted by the University of Iowa Center for Public Health Studies examined utilization of physical therapy between 2003 and 2007 (including almost 63,000 physical therapy outpatients in Iowa and South Dakota) found that patients who sought care from a physical therapist without a physician's prescription had fewer physical therapy visits than those who were referred by a physician. The authors conclude:

> *"...our findings do not support the assertion that [patient] self-referral leads to over-use of care or discontinuity in care, based on a very large population of individuals in a common private health insurance plan with no requirement for PT referral or prohibition on patient self-referral. We consistently found lower use in the self-referral [direct access] group, after adjusting for key demographic variables, diagnosis group, and case mix. We also found that individuals in both groups were similarly engaged with the medical care system during their course of care and afterwards."*

In addition, direct consumer access to physical therapy decreases unnecessary physician visits when the only reason an individual schedules a physician visit is to obtain a prescription for physical therapy. Eliminating this visit saves the patient the cost of the co-payment, saves the insurance company the cost of the visit and the individual receives necessary care more expediently.

A study which analyzed 4 years of Blue Cross Blue Shield of Maryland claims found that paid claims for physician referred physical therapy were 2.2 times higher than paid claims for physical therapy attained through direct access. United Healthcare, one of the largest health insurance providers in the country, now provides coverage for direct access to physical therapy in recognition of the cost savings that are being realized.

Direct consumer access leads to fewer visits resulting in decreased costs and better outcomes. A systematic review, published in *Physical Therapy* January 2014 that concluded that

> *"...physical therapy by direct access compared with referred episodes of care is associated with improved patient outcomes and decreased costs."*

Physical therapists and physicians are an integral part of the health care team. Physical therapists have a long history of collaborating with other health care providers, including physicians. Direct access will not change this relationship; it would merely allow another access point into the health care system. Direct consumer access to physical therapy allows consumers better access, increased choice, and cost containment. This is good for individuals, this is good for health care and this is good for the State of Michigan.

Sincerely,

Susan Ann Talley, PT, DPT, PhD(c)
President, Michigan Physical Therapy Association

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The Michigan Public Health Code has an unnecessary restriction on consumer access to physical therapy services by requiring that a person have a physician prescription prior to receiving treatment by a physical therapist. Michigan is one of only 2 states left with this restriction.

The opposition to physical therapists evaluating and treating individuals without a physician prescription claim that it will increase cost and cause harm to patients. They argue that physical therapists will miss serious medical disease resulting in harm. However, they are unable to present data to substantiate these claims, but yet are successful in their lobbying efforts to prevent legislative change by promoting fear.

The published facts surrounding this issue include:

1. Forty-eight states and the District of Columbia have direct consumer access for treatment by a physical therapist.

   http://www.apta.org/uploadedFiles/APTAorg/Advocacy/State/Issues/Direct_Access/DirectAccessbyState.pdf

2. There is no relationship between direct consumer access and malpractice claims nor is there an increase in reports of physical therapist malpractice following a change to direct consumer access. Additionally, the major insurance carriers for physical therapist liability insurance have the same premiums for therapists in direct consumer access and non-direct consumer access states. These insurance carriers affirm that there is no increase in malpractice claims in those states with direct consumer access.

   2005 Moore JH, McMillan D, Rosenthal M, Weishaar M. Risk determination for patients with direct access to physical therapy in military health care facilities. *J Orthop Sports Phys Ther*; 35(10):674-678.

   2006 Lane M. Vice President of Professional Standards and Assessment of Federation of State Boards of Physical Therapy (FSBPT) letter to the American Physical Therapy Association (APTA).

   2007 Sandstrom R. Malpractice by physical therapists: descriptive analysis of reports in the National Practitioner Data Bank public use data file, 1991-2004. *J Allied Health*; 36:201-208.

   2013 Loughran M., President Healthcare Division of Healthcare Providers Service Organization (HPSO) letter to the American Physical Therapy Association (APTA) January 10, 2013.

   2013 Green M, Shoemaker MJ, Basore T, Polso A. Physical therapist professional autonomy, medical malpractice, and adverse professional license action: results from a twenty-year review of the National Practitioner Data Bank. *Physical Therapy Journal of Policy, Administration, and Leadership, 2013;*13(3),:J1-J10.

3. In many settings such as hand therapy, there is considerable overlap in scope of practice between physical therapists and occupational therapists. However, despite physical therapists having more training in musculoskeletal evaluation and management than occupational therapists, consumers may go directly to see an occupational therapist in the state of Michigan. Those who oppose direct consumer access for physical therapists did not raise the issue of referral of prescription when occupational therapists gained licensure in 2009. This highlights the fact that physician opposition is the result of perceived competition, not patient safety.

4. All licensed physical therapists have graduated from a physical therapy program accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE). CAPTE is the only accrediting body for physical therapist education and is approved by the U.S. Department of Education. Physical Therapist education and training prepares the graduate for direct consumer access and includes an emphasis on screening for diseases and conditions outside the scope of practice of a physical therapist. Physical therapists must meet the same educational standards whether they will practice in a direct consumer access state or not. Physical therapists must pass the National Physical Therapist Exam (NPTE) for licensure regardless of whether that state has direct consumer access or not. It is inconceivable how a physical therapist can graduate from an accredited program, pass the NPTE, and practice safely under direct consumer access in 48 other states, the District of Columbia, and the United States Military, but cross the border into Michigan and suddenly become a danger to patients.

5. Physical therapists are trained to determine a physical therapy diagnosis (not a medical diagnosis). They are trained to screen for and identify health conditions that lie outside the PT scope of practice and require referral to a physician. This is what we currently do because, despite the physician prescription requirement, physical therapists are held liable for ensuring that we are practicing within our scope of practice and that the referral from the physician is appropriate. Eliminating the prescription requirement changes the accessibility of physical therapy services for the consumer – it would not change our scope of practice. Furthermore, the majority of prescriptions for physical therapy are non-specific (e.g. "shoulder pain") and require the physical therapist to determine a physical therapy diagnosis. Research shows that more specific prescriptions containing a specific diagnosis from a physician do not result in a better clinical outcome.

2008 Brooks G, Dripchak S, Venbeveren P, Allaben S. Is prescriptive or open referral related to physical therapy outcomes in patients with lumbar spine-related problems? *J Orthop Phys Ther* 2008; 39:109-115.
NOTE: This study was conducted in Michigan

2005 Davenport TE, Watts HG, Kulig K, Resnik C. Current status and correlates of physicians' referral diagnoses for physical therapy. *J Orthopaedic Sports Phys Ther.* 2005;35(9):572-579.

1994 Clawson AL, Domholdt E. Content of physician referrals to physical therapists at clinical education sites in Indiana. *Phys Ther.* 1994;74:356-360.

6. Childs et al (2005) found that both physical therapists and student physical therapist performed better on a standardized examination regarding knowledge of management of musculoskeletal conditions than medical students, physician interns, residents, and a variety of physician specialty groups except orthopedists. The authors concluded that physical therapists can provide safe and effective care in outpatient musculoskeletal practice settings.

2005 Childs JD, Whitman JM, Sizer PS, et al. A description of physical therapists' knowledge in managing musculoskeletal conditions. BMC Musculoskel Disord. 2005;6:32.

7. Boissonnault et al (2010) reported on 81 patients seen under direct access in a non-profit, hospital-based outpatient department. Retrospective physician review of physical therapist management decisions determined that these decisions were appropriate 100% of the time, which included making referrals for additional imaging studies, medical consultation, and medication for pain management.

2010 Boissonault WG, Badke MB, Powers JM. Pursuit and implementation of hospital-based outpatient direct access to physical therapy services: an administrative case report. *Phys Ther.* 2010;90:100-109.

8. Physical therapists have 3 years of training in musculoskeletal evaluation and management. Non-orthopedic physicians have considerably less training. DiCaprio et al noted that: "Nearly half of American medical schools allow their students to graduate without having had any formal training-clinical or basic science-in musculoskeletal medicine. Fewer than half of the medical schools offer a distinct course in the preclinical years, and four of five do not require a clinical rotation." Of the 25 schools that did require a clinical rotation only 4 schools required the clinical to last 4 weeks, all others were as short as 2 weeks. Skelley et al found that less than 20% of medical students at a sample institution passed a musculoskeletal competency exam.

2003 DiCaprio et al. Curricular Requirements for Musculoskeletal Medicine in American Medical Schools. *J Bone Joint Surg Am.* 2003; 85: 565-567.

2012 Skelley NW, Tanaka MJ, Skelley LM, LaPorte DM. Musculoskeletal education: an institutional survey. *J Bone Joint Surg AM.* 2012; 94: e146(1-7).

9. Direct consumer access does not increase cost. In fact, a 2011 review of over 62,000 Iowa and South Dakota non-Medicare claims data revealed that episodes of physical therapy care under direct consumer access ***cost less*** than those that were referred by a physician. The same finding was previously reported in a study published in 1997 that compared Maryland Blue Cross claims for direct consumer access and physician referral episodes for physical therapy: Patients who directly accessed physical therapy services saved, on average, $1200 per service episode over those who went through a physician's office first. Comparable evidence can be found in Scotland, the United Kingdom, and the Netherlands.

2014 Ojha HA, Snyder RS, Davenport TE. Direct access compared with referred physical therapy episodes of care: a systematic review. Phys Ther. 2014;94:14–30.

2011 Pendergast J, Kliethermes SA, Freburger JK, Duffy PA. A comparison of health care use for physician-referred and self-referred episodes of outpatient physical therapy. *Health Services Research.* 2011:1-22. DOI: 10.1111/j.1475-6773.2011.01324.x

1997 Mitchell JM and deLissov G. A comparison of resource use and cost in direct access versus physician referral in referral episodes of physical therapy. *Phys Ther.* 1997;77(1):10-18.

2008 Leemrijse CJ, Swinkels CS, Veenhof C. Direct access to physical therapy in the Netherlands: results from the first year in community-based physical therapy. *Phys Ther*, 2008;88(8): 936-946.

1997 Hensher M. Improving general practitioner access to physiotherapy: a review of the economic evidence. *Health Serv Manage Res.* 1997; 10(4):225-230.

2007 Holdsworth LK, Webster VS, McFadyen AK. What are the costs to NHS Scotland of self-referral to physiotherapy? Results of a national trial. *Physiotherapy.* 2007;93(1):3-11.

10. No evidence exists to show that accessing treatment from a physical therapist results in misdiagnosis and harm. Quite the opposite is true. Over 20 published case reports demonstrate physical therapists' ability to screen for medical disease that required further physician evaluation or management. Many of these cases were patients referred from physicians with incorrect diagnoses.

Weishaar MD, McMillian DJ, Moore JH. Identification and management of 2 femoral shaft stress injuries. *J Orthop Sports Phys Ther.* 2005;35(10):665-673.

Mintken PE, Boyles RE. Tarsometatarsal joint injury in a patient seen in a direct-access physical therapy setting. *J Orthop Sports Phys Ther.* 2009;39(1):28.

Neilson B, Boyles, RE. Osteochondral defect of the medial femoral condyle. *J Orthop Sports Phys Ther* 2009;39(6):490.

Thein-Nissenbaum J, Boissonnault WG. Differential diagnosis of spondylolysis in a patient with chronic low back pain. *J Orthop Sports Phys Ther.* 2005;35(5):319-326.

Sasaki M. Cervical cord compression secondary to ossification of the posterior longitudinal ligament. *J Orthop Sports Phys Ther.* 2005;35(11):722-729.

Ross MD, Bayer E. Cancer as a cause of low back pain in a patient seen in a direct access physical therapy setting. *J Orthop Sports Phys Ther.* 2005;35(10):651-658.

Garber MB. Diagnostic imaging and differential diagnosis in 2 case reports. *J Orthop Sports Phys Ther.* 2005;35(11):745-754.

Asavasopon S, Jankoski J, Godges JJ. Clinical diagnosis of vertebrobasilar insufficiency: resident's case problem. *J Orthop Sports Phys Ther.* 2005;35(10):645-650.

Browder DA, Erhard RE. Decision making for a painful hip: a case requiring referral. *J Orthop Sports Phys Ther.* 2005;35(11):738-744.

Cleland JA, Venzke JW. Dermatomyositis: evolution of a diagnosis. *Phys Ther.* 2003;83(10): 932-945.

Gray JC. Diagnosis of intermittent vascular claudication in a patient with a diagnosis of sciatica. *Phys Ther.* 1999;79:582-590.

VanWyeWR. Patient screening by a physical therapist for nonmusculoskeletal hip pain. *Phys Ther.* 2009;89:248-256.

Mechelli F, Preboski Z, Boissonnault W. Differential diagnosis of a patient referred to physical therapy with low back pain: abdominal aortic aneurysm. *J Orthop Sports Phys Ther.* 2008;38(9):551-557.

Cleland JA, Venske JW. Dermatomyositis: evolution of a diagnosis. *Phys Ther.* 2003;83:932-945.

Greenwood MJ, Erhard RE, Jones DL. Differential diagnosis of the hip vs. lumbar spine: five case reports. *J Orthop Sports Phys Ther.* 1998;27(4):308-315.

Browder DA, Erhard RE. Decision making for a painful hip: a case requiring referral. *J Orthop Sports Phys Ther.* 2005;35:738-744.

Johnson MP, Abrams SL. Historical perspectives of autonomy within the medical profession: considerations for 21st century physical therapy practice. *J Orthop Sports Phys Ther.* 2005;35(10):628-636.

Sasaki M. Cervical cord compression secondary to ossification of the posterior longitudinal ligament. *J Orthop Sports Phys Ther.* 2005;35:722-729.

Asavasopon S, Jankoski J, Godges JJ. Clinical diagnosis of vertebrobasilar insufficiency: resident's case problem. *J Orthop Sports Phys Ther.* 2005;35:645-650.

Mamula CJ, Erhard RE, Piva SR. Cervical radiculopathy or parsonage-turner syndrome: differential diagnosis of a patient with neck and upper extremity symptoms. *J Orthop Sports Phys Ther.* 2005;35(10):659-664.

Robert G, Stevens A. Should general practitioners refer patients directly to physical therapists? *British Journal of General Practice.* 1997;47:314-318.

Stowell T, Cioffredi W, Greiner A, Cleland J. Abdominal differential diagnosis in a patient referred to a physical therapy clinic for low back pain. *J Orthop Sports Phys Ther.* 2005;35(11):755-764.

Crowell MS, Gill NW. Medical screening and evacuation: cauda equine syndrome in a combat zone. *J Orthop Sports Phys Ther.* 2009;39:541-549.

APTA
American Physical Therapy Association

NEWS RELEASE

[illegible] North Fairfax Street
Alexandria, VA 22314-1488
703-684-2782
703-684-7343 fax
www.apta.org

DIRECT ACCESS TO PHYSICAL THERAPISTS ASSOCIATED WITH LOWER COSTS AND FEWER VISITS, NEW STUDY SAYS

For Immediate Release

Contact: Erin Wendel
(703) 706-3397
erinwendel@apta.org

ALEXANDRIA , VA -- A new study suggesting that "the role of the physician gatekeeper in regard to physical therapy may be unnecessary in many cases" could have significant implications for the US health care system, says the American Physical Therapy Association (APTA).

The study, published ahead of print September 23 in the journal *Health Services Research* (*HSR*), reviewed 62,707 episodes of physical therapy using non-Medicare claims data from a Midwest insurer over a 5-year period. Patients who visited a physical therapist directly for outpatient care (27%) had fewer visits and lower overall costs on average than those who were referred by a physician, while maintaining continuity of care within the overall medical system and showing no difference in health care use in the 60 days after the physical therapy episode.

The study is noteworthy because services delivered by physical therapists account for "a significant portion" of outpatient care costs in the United States, according to the study, and some health insurance plans require a physician referral for reimbursement of these services. In addition, although 46 states and the District of Columbia now allow some form of direct access to physical therapists for treatment/intervention, some of them nonetheless impose restrictions if patients have not been referred by a physician.

"Physical therapists have long known that direct access to our services is safe and effective," said APTA President R. Scott Ward, PT, PhD. "The elimination of referral requirements and other restrictions has been a priority of APTA for decades. This study provides further evidence that direct access to physical therapists could go a long way toward helping to make health care more affordable and accessible for all. We encourage researchers and insurers to continue to further investigate this important issue that could have a profound impact on patient care."

"When patients choose direct access to a physical therapist, it does not mean the end of collaboration with their physician, nor does it diminish continuity of care," added Thomas DiAngelis, PT, DPT, president of APTA's Private Practice Section. "We believe the results of this study will support our efforts to work with legislators and physician groups to establish policies that reduce unnecessary regulations, improve access, and build models of delivery that best serve the patient and the health care system. Although this study focused on direct access, it is not about the provider. It is about the patient. It means better opportunities to provide the proper care to those who need it, when they need it."

Led by Jane Pendergast, PhD, professor of biostatistics and director of the Center for Public Health Studies at the University of Iowa, the study retrospectively analyzed 5 years (2003-2007) of private health insurance

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claims data from a Midwest insurer on beneficiaries aged 18-64 in Iowa and South Dakota. A total of nearly 63,000 outpatient physical therapy episodes of care were analyzed – more than 45,000 were classified as physician-referred and more than 17,000 were classified as "self-referred" to physical therapists. Physical therapy episodes began with the initial physical therapist evaluation and ended on the last date of services before 60 days of no further visits. Episodes were classified as physician-referred if the patient had a physician claim from a reasonable referral source in the 30 days before the start of physical therapy. Researchers found that self-referred patients had fewer physical therapy visits (86% of physician-referred) and lower allowable amounts ($0.87 for every $1.00 of physician-referred) during the episode of care, after adjusting for age, gender, diagnosis, illness severity, and calendar year. In addition, overall related health care use – or care related to the problem for which physical therapy was received, but not physical therapy treatment – was lower in the self-referred group after adjustment. Examples of this type of care might include physician services or diagnostic testing. Potential differences in functional status and outcomes of care were not addressed.

"Health care use did not increase in the self-referred group, nor was continuity of care hindered," the researchers write. "The self-referred patients were still in contact with physicians during and after physical therapy. Concerns about patient safety, missed diagnoses, and continuity of care for individuals who self-refer may be overstated."

According to Rick Gawenda, PT, president of APTA's Section on Health Policy and Administration, the study should cause insurers and policymakers to rethink the physician gatekeeper concept when it comes to physical therapist services. "Evidence shows that, in the case of physical therapy, the physician gatekeeper model is doing exactly the opposite of what it was originally designed to do; it does not reduce ineffective and duplicate care nor reduce health care costs," says Gawenda. "It's time to end the physician referral requirement in every state, and it's time for all payers to embrace direct access to physical therapists."

Earlier research has supported direct access to physical therapists, but the new *HSR* study is the most comprehensive to date. A 1994 study analyzed 4 years of Blue Cross Blue Shield of Maryland claims data and found that total paid claims for physician referral episodes to physical therapists were 2.2 times higher than the paid claims for direct access episodes. In addition, physician referral episodes were 65% longer in duration than direct access episodes and generated 67% more physical therapy claims and 60% more office visits. The *HSR* study looked at a far more extensive number of episodes than the previous study, and also controlled for illness severity and other factors that could have affected the patients' outcomes.

"In summary," the researchers write, "our findings do not support the assertion that self-referral leads to overuse of care or discontinuity in care, based on a very large population of individuals in a common private health insurance plan with no requirement for PT [physical therapy] referral or prohibition on patient self-referral. We consistently found lower use in the self-referral group, after adjusting for key demographic variables, diagnosis group, and case mix. We also found that individuals in both groups were similarly engaged with the medical care system during their course of care and afterwards."

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The American Physical Therapy Association (APTA) represents more than 77,000 physical therapists, physical therapist assistants, and students of physical therapy nationwide. Learn more about conditions physical therapists can treat and find a physical therapist in your area at www.moveforwardpt.com. Consumers are encouraged to follow us on Twitter (@moveforwardpt) and Facebook.

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The Practice Practice Section (PPS) is the business section of APTA that fosters the growth, economic viability, and business success of physical therapist-owned practices to benefit the public.

The Section on Health Policy and Administration (HPA) is a specialty component of APTA. The mission of the HPA Section is to transform the culture of physical therapy through initiatives that enhance professionalism, leadership, management, and advocacy to foster excellence in autonomous practice for the benefit of members and society.

Co-authors of the study were Stephanie A. Kliethermes, MS, a doctoral candidate in biostatistics at the Center for Public Health Studies, University of Iowa; Janet K. Freburger, PT, PhD, research associate and fellow at the Sheps Center for Health Services Research and a scientist at the Institute on Aging at the University of North Carolina, Chapel Hill; and Pamela A. Duffy, PT, PhD, OCS, CPC, assistant professor, Public Health Program, at Des Moines University.

The study was funded by a grant from APTA and its sections on Private Practice and Health Policy and Administration.

Reference

Pendergast J, Kliethermes SA, Freburger JK, Duffy PA. A comparison of health care use for physician-referred and self-referred episodes of outpatient physical therapy. *Health Services Research*. Published ahead of print September 23, 2011. DOI: 10.1111/j.1475-6773.2011.01324.x

Michigan Physical Therapy Association
MPTA, 1390 Eisenhower Place, Ann Arbor, MI 48108
Tel: 734-929-6075, Email: mpta@mpta.com Website: www.mpta.com

WHAT IS THE SCOPE OF PRACTICE OF PHYSICAL THERAPY?

Physical Therapy is a health care profession that examines, identifies, educates and provides treatment for an individual's impairments, dysfunctions, disorders and disabilities of the musculoskeletal, neuromuscular, and cardiopulmonary systems. In addition, physical therapists consult with other members of the health care team.

These impairments, dysfunctions, disorders and disabilities result from congenital, genetic, disease, or trauma related conditions.

The physical therapist (PT) examines a person's ability to move as it relates to underlying problems with bones, joints, cartilage, ligaments, fascia, muscle, skin, nerves, etc. The data that is collected during this examination and the patient interview helps physical therapists to know why, how, when, and what to treat systematically.

Contemporary health care requires a multi-disciplinary approach for quality care.

In all 50 states plus Washington, DC and the US Military, contemporary Physical Therapy practice includes patient evaluation, education and consultation without a physician referral. In 48 states plus Washington DC and the US Military, physical therapists may also render treatment without a physician referral. Only Michigan and Oklahoma prohibit a consumer from seeking physical therapy services directly.

Physical therapist assistants (PTAs) assist physical therapists (PTs) in the delivery of physical therapy services under the delegation and supervision of physical therapists (PTs).

WHAT ARE THE EDUCATIONAL AND LICENSURE REQUIREMENTS FOR PT?

All PT Education Programs in Michigan currently offer a Doctoral degree (DPT-Doctor of Physical Therapy) for entry into Physical Therapy. Today nearly all PT education programs in the United States offer a Doctoral degree (DPT).

Over the years, all licensed physical therapists (PTs) – whether receiving the doctoral, master's or bachelor's degree have been educated to identify the nature or cause of the problem to be treated, to indentify problems that are outside the scope of physical therapy practice and to refer the patient to a physician.

After graduation, all physical therapists (PTs) must pass the National Physical Therapist Exam to become licensed. While the scope of practice varies between some states, all physical therapists are educated to be able to practice in every state, including practice without physician referral.

PTAs are trained at an Associate's degree level at a nationally accredited Physical Therapist Assistant education program. All fifty states regulate the practice of a PTA. In Michigan, PTAs are required to be licensed.

PHYSICAL THERAPY IS NOT A GENERIC TERM OR LABEL FOR USE BY OTHER HEALTH CARE PRACTITIONERS FOR SERVICES THEY PROVIDE

Certain procedures and measures (use of ultrasound, electrical stimulation, heat, cold, exercise, etc.) utilized by Physical Therapists (Physiotherapists) are held in common with other professions such as Athletic Trainers, Occupational Therapists, Chiropractic, Medicine, etc. However the manner and philosophy of intervention strategies in the use of these procedures and measures is unique to each profession.

As such, for a procedure to be called Physical Therapy or Physiotherapy it must be provided within the philosophical and ethical contexts of the PT profession. These contexts are only provided by a professional Physical Therapist (physiotherapist) or through services directly supervised by a professional Physical Therapist (Physiotherapist).

When any of the "in common" measures or procedures is utilized by other professions they should be identified as being part of that profession and practice. To call it Physical Therapy or Physiotherapy under such circumstances would be misrepresentation to the client being served and would be inappropriate.

Michael Loughran | President | michael.loughran@aon.com

January 10, 2013

Mr. Justin Elliot
Associate Director, State Government Affairs
American Physical Therapy Association
1111 Fairfax Street
Alexandria, VA 22314-1488

RE: Direct Access Liability

Dear Mr. Elliot,

The national office of the American Physical Therapy Association awarded its exclusive endorsement to the professional liability insurance program marketed by Healthcare Providers Service Organization (HPSO) and underwritten by American Casualty Company of Reading, Pennsylvania, a CNA Company, in 1992. Today, we are a leading provider of professional liability coverage to the physical therapy profession, insuring over 90,000 PTs, PTAs, and students of physical therapy.

We are aware that 47 states and the District of Columbia currently allow physical therapists direct access to patients without a physician referral. We regularly monitor trends to be sure that we are adequately accounting for all risks and have not noted any trends relative to the practice of physical therapy in direct access states. The current actuarial summary of the CNA/HPSO Program indicates that the average loss experience from physical therapy services in direct access states is comparable to the loss experience in those states where direct access has not yet been approved.

Based on the above, our underwriting practices have not changed. Direct access is not a risk factor that we specifically screen for in the underwriting of our program nor do we charge a premium differential for physical therapists in direct access states. We currently have no specific underwriting concerns with respect to direct access for physical therapists.

Sincerely,

Michael Loughran
President, Healthcare

Cc: Michael A. Scott/CNA HealthPro

Aon Affinity | Healthcare Division
159 E. County Line Road | Hatboro, PA 19040
t +1 215 773 4127 | f +1 215 773 4587 | www.aon.com

Say YES to Direct Consumer Access to Physical Therapy Services in Michigan

- **Michigan is one of only two states (along with Oklahoma) that continue to deny direct consumer access to the services of a physical therapist.** Forty-eight (48) states, along with the District of Columbia and the US military to have granted consumers the freedom to seek physical therapy evaluation and treatment without a referral. No state that has enacted a direct consumer access law has ever repealed it.

- **The current referral mandate causes unnecessary delays in the provision of physical therapy to individuals who need it.** Delays in care result in higher costs, decreased functional outcomes, and frustration to patients seeking physical therapy treatment.

- **Direct consumer access saves money for both consumers and insurers.** A 2011 review of over 62,000 Iowa and South Dakota non-Medicare claims data revealed that episodes of physical therapy care under direct access cost nearly 20% ***less*** and had nearly 20% ***fewer*** visits than those that were referred by a physician. A similar finding was previously reported in a study published in 1997 that compared Maryland Blue Cross claims for direct access and physician referral episodes for physical therapy.

- **Direct consumer access to physical therapy services is safe.** Physical therapists are trained to screen for signs and symptoms that might indicate a condition requiring the attention of a physician or other healthcare provider. State law already requires a physical therapist to refer a patient to an appropriate healthcare provider when the patient's condition requires care beyond the scope of physical therapy. Furthermore, the leading provider of professional liability coverage for physical therapists does not charge higher premiums to physical therapists practicing in states with direct consumer access, because there has been no increase in risk or claims in those states.

- **Direct consumer access makes physical therapy services more accessible to more people.** By providing an additional entry point into the health care system, particularly in rural areas, direct consumer access results in more successful patient outcomes. Direct access also gives consumers of health care services the freedom of choice in selecting health care professionals.

- **Direct consumer access promotes preventative health care.** Physical therapists educate patients on how to avoid injury and re-injury during activities of daily living and recreation. Direct consumer access also allows early intervention and on-site treatment of injuries in schools and industry. This decreases lost wages in industry because of fewer injuries and earlier return to work.

- **Graduating physical therapy students educated in Michigan (with Michigan tax dollars) are hesitant to practice in a state with such restrictive referral requirements.** When our graduates leave Michigan, our tax dollars are wasted and our economy is further damaged.

- **Michigan consumers can go directly to an occupational therapist or chiropractor to receive rehabilitative services, but cannot go directly to a physical therapist.** The prescription requirement for physical therapy services is arbitrary and limits consumers' choice of rehabilitation providers.

Remove unnecessary barriers to safe and cost-effective Physical Therapy services

Support Direct Consumer Access to PT Services in MI

Say YES to Direct Consumer Access to Physical Therapy Services
Support SB 690!

Note: All bills introduced 11/14/13. Action needed by 12/31/14 when this legislative session ends. Bills that are not acted upon by the 12/31/14 will expire and will need to be reintroduced in 2015-16 session.

SB 690 - Direct Consumer Access to PT Services Bill. Sponsors: John Moolenaar (primary)
David Hildenbrand, John Pappageorge, Rebekah Warren, Michael Green, Arlan Meekhof, Thomas Casperson, Jack Brandenburg

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Additional Bills Tie-Barred to SB 690

SB 691 - Sponsors: Rebekah Warren (primary)
David Hildenbrand, John Moolenaar, John Pappageorge, Michael Green, Arlan Meekhof, Thomas Casperson, Jack Brandenburg
•Insurance; health care corporations; reimbursement for physical therapy services; allow health care corporation to withhold unless patient has a prescription from a licensed health professional.

SB 692 - Sponsors: Thomas Casperson (primary)
David Hildenbrand, John Moolenaar, John Pappageorge, Rebekah Warren, Michael Green, Arlan Meekhof, Jack Brandenburg
•Insurance; prudent purchaser agreements; reimbursement for physical therapy services; allow insurance companies to withhold unless patient has a prescription from a licensed health professional.

SB 693 - Sponsors: David Hildenbrand (primary)
John Moolenaar, John Pappageorge, Rebekah Warren, Michael Green, Arlan Meekhof, Thomas Casperson, Jack Brandenburg
•Worker's compensation; benefits; reimbursement for physical therapy services; allow employer to withhold unless patient has a prescription from a licensed health professional.

SB 694 - Sponsors: Michael Green (primary)
David Hildenbrand, John Moolenaar, John Pappageorge, Rebekah Warren, Arlan Meekhof, Thomas Casperson, Jack Brandenburg
•Insurance; health; reimbursement for physical therapy services; allow insurers to withhold unless patient has a prescription from a licensed health professional.

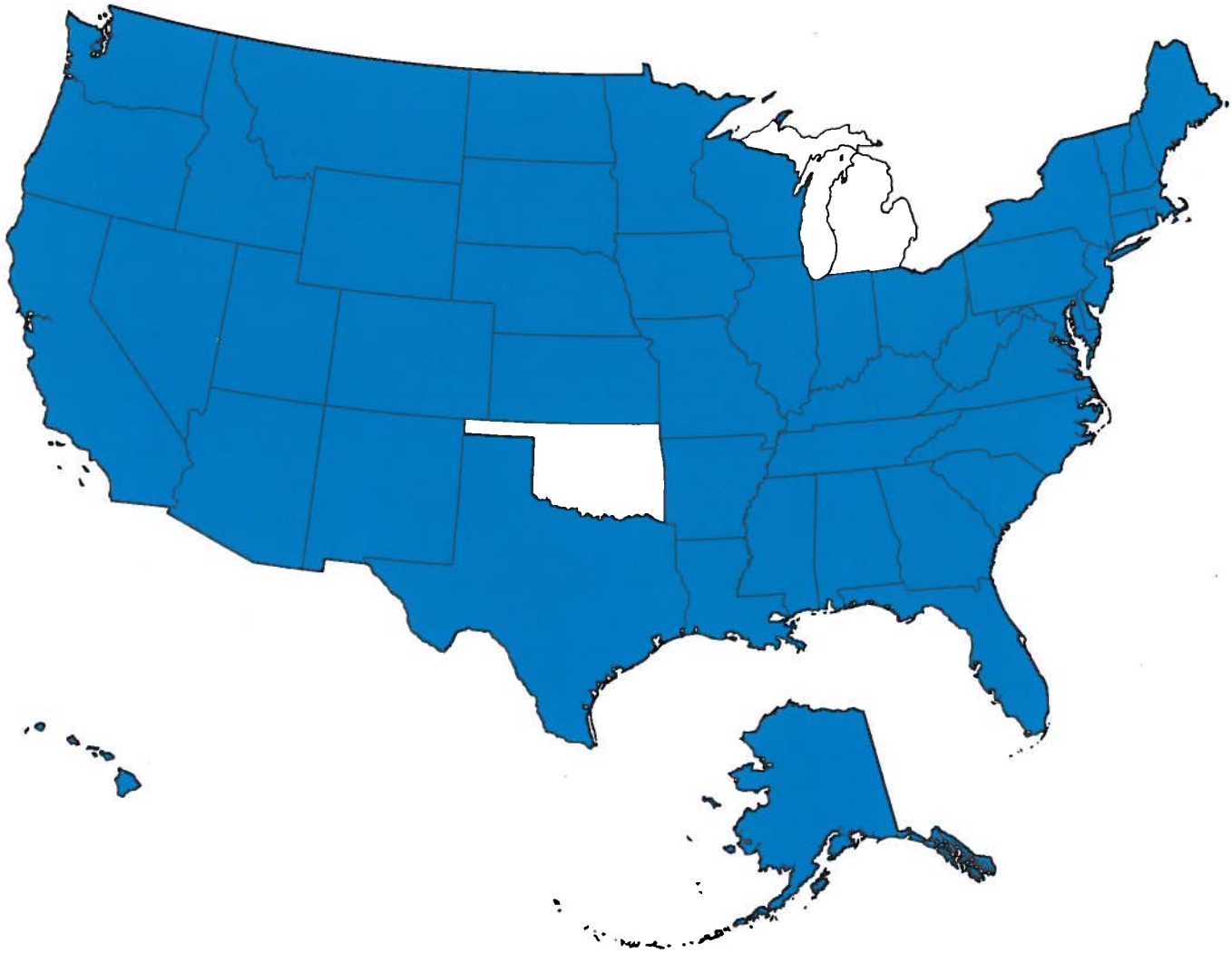
Rationale / Procedures for tie-barred bills:

- In order to gain legislative support for SB 690, these 4 tie-barred bills were also introduced.
    - The tie-barred bills would amend various insurance codes in Michigan law.
    - The tie-barred bills permit third party payers (health insurance companies) to continue to require a prescription / referral for physical therapy services should they so desire.
    - This is currently what third party payers do; SB 690 does not change that.
    - Therefore, third party payer concerns that SB 690 will increase costs are unfounded.
    - Direct consumer access is NOT a mandate for insurance carriers.

- Tie-barred bills are voted on as a group, not individually.
- SB 690 plus these 4 tie-barred bills will either ALL pass or fail together.

DIRECT ACCESS
TO PHYSICAL THERAPIST SERVICES

Is Yours a Direct Access State?



Alabama	2012
Alaska	1986
Arizona	1983
Arkansas	1997
California	1968
Colorado	1988
Connecticut	2006
Delaware	1993
District of Colombia	2007
Florida	1992
Idaho	1987
Illinois	1988

Indiana	2013
Iowa	1988
Georgia	2006
Hawaii	2010
Kansas	2007
Kentucky	1987
Louisiana	2003
Maine	1991
Maryland	1979
Massachusetts	1982
Minnesota	1988
Mississippi	2006
Missouri	1999

Montana	1987
Nebraska	1957
Nevada	1985
New Hampshire	1988
New Jersey	2003
New Mexico	1989
New York	2006
North Carolina	1985
North Dakota	1989
Ohio	2004
Oregon	1993
Pennsylvania	2002
Rhode Island	1992

South Carolina	1998
South Dakota	1986
Tennessee	1999
Texas	1991
Utah	1985
Virginia	2001
Vermont	1988
Washington	1988
West Virginia	1984
Wisconsin	1989
Wyoming	2003

TOTAL = 48 + DC

YOUR CONSTITUENTS DESERVE IT.